



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

April 3, 2008

Todd Winder
Oneida County Hospital Home Care
150 North 200 West
Malad, Idaho 83252

Dear Mr. Winder:

This is to advise you of the findings of the Medicare recertification survey, which was concluded at your facility, Oneida County Hospital Home Care, on April 2, 2008.

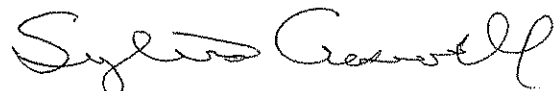
Enclosed are a Statement of Deficiencies/Plan of Correction, Form CMS-2567 and a State Licensure Statement of Deficiencies/Plan of Correction which state that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,



PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/02/2008
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS No deficiencies were cited during the Medicare recertification survey of your Home Health Agency. Oneida County Hospital Home Care is in compliance with the requirements of 42 CFR Part 484, Conditions of Participation for Home Health Agencies. The surveyor who conducting the Medicare certification survey was: Patrick Hendrickson, RN, HFS.	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/02/2008
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>No deficiencies were cited during the Idaho state licensure survey of your Home Health Agency. Oneida County Hospital Home Care is in compliance with the requirements of IDAPA 16.03.07, Rules for Home Health Agencies. The surveyor conducting the state licensure survey was:</p> <p>Patrick Hendrickson, RN, HFS.</p>	N 000			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1